



USA MEDDAC-ALASKA

PATIENT ADVISORY COUNCIL

MEMBERSHIP APPLICATION



APPLICANT INFORMATION

Name:

Date of birth:

Sponsor Last 4 SSN:

DEROS:

Current address:

City:

State:

ZIP Code:

Have you or a family member received care at BACH or one of its two Troop Health Clinics? Yes ___ No ___

If yes, at which facility?

CONTACT INFORMATION

E-mail address:

Home Phone:

Mobile:

Preferred method of receiving communication about the council: E-mail ___ Regular Mail ___ Home Phone ___ Mobile ___

Can we share contact information with other members of the council: Yes ___ No ___

ABOUT YOU

Why would you like to be on the council?

What issues would you like to see the council address?

What special interest or experience would you like to offer to the council?

SIGNATURE

I authorize the verification of the information provided on this form.

Signature of applicant:

Date:

Please e-mail completed form to akmedpao@amedd.army.mil or return to the Patient Advocate Office.

An interview will be scheduled for individuals meeting all initial screening criteria.